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Case 2:06-cv-00172-WH-10 Initial SE Filed, 06/05/2006 Page 4 of 27 28 Facility: Chitchille Month ALACUDA. 23 24 | 25 | 26 Location: DOD 15 16 17 | 18 | 19 | 20 | 21 | 22 | Signature CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED DEPARTMENT OF CORRECTIONS Initials - PRN Medication and notes on Reverse Side Medication Administration Record 11 12 13 14 TO PUNCT 10 6 Φ \\$ignature φ (1 ()) I) b 4 က Inmate Name: Cloc Dun, Diblo Initials Ø 40 Times Len Jano Ġ Inmate Number: 1595110 Allergies: Code in D 1693 Bid x 3 dougs, 8-16-93 F. + id x 3-46-48 8/17/43 STRUM I STAND Pharmacy Dispensed Pharmacy Dispensed 8-10-03 Dr. LONSON R.Ph. Pharmacy Dispensed 8-19-90 Per L. 2018ON 8-21-02 x 5-16-6 05W KVO (NO) 1/12 Medication Signature F-30-C Start Stop R.Ph. R. Ph.

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Inmate Name: Clackler, Debra	Inmate Number: 159516 Allergies: A eine			يا	<u> </u>	R.Ph.	"	
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Case 2:06-cv-00172-WHA-CSU SEBVICES:24-UTHORIZANT/03/NOOETTERge 7 of 33

Clackler, Debra	T NY	
	inmate Number:	159516CL
X-Ray: Ultrasound	Effective Dates:	11/16/2005
Visits authorized for 60 days from effective date.	Visits Authorized:	1
Tutwiler Prison For Women		
15626621	Telephone Number:	(334)395-5973 Ext 14
	Tutwiler Prison For Women	X-Ray: Ultrasound Effective Dates: Visits authorized for 60 days from effective date. Tutwiler Prison For Women Contact Name:

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

> The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

	V .	
李章 李章 Sclinical Sumn	uary or Attached Report	
		:
*** For security and safety, please do not i	nform patient of possible follow-up appoint	4. 4.4.4
V/L		nents. ^^*
Circumstant of Council (1) Division		
Signature of Consulting Physician:	Date	Time
Reviewed and Signed By		
Medical Director:		
	Date	Time

Case 2:06-cv-00172-WHA-CS Please send this form with	MANAGEMEN must be Complete and	FREFERRAL R Legible, You must Type or	6/0 5/2000/50 RM age 8 of 33 t
Trease della tills form with		att	Fc the time of the Appointment
Can Name All I	Patient Name: (Last, Firs	RAPHICS	
844 - TUTWILER	11/1/		Date: (mm/dd/yy)
Sito Dhamat	Sucker.) lbra	1/1/6105
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334-514-6269	Manlles	10	11 = 1 (7/1
Site Fax #	nmate #	Debra	126154
334-514-9559	in indice p		PHS Custody Date: (mm/dd/yy)
004-014-3333	1595/6		08(10,91)
Will there be a charge? Sex	SS Number		Potential Release Date: (mm/dd/yy)
☑ Yes ☐ No ☐ Male ☑ Female -	41780	9985	() S O O O O
		<u> </u>	001001
Responsible party:	Health Ins.(Excludes Medic	are/Medicaid Managed Care aitemati	ive plans)
	22 Over, be specific (Excludes	Medicare, Medicaid and Veterans A	dministration Services):
Requesting Provider: Physician	CLINIC	AL DATA	
11.00	□ NP, PA □ Deptal	Ulace as an incident	
Samuel Engelhardt, M.D.	7h-1/	rustory of Illness/injury	Sypmitoms with Date of Onset:
Facility Medical Director Signature and Date	11-10	aburr	heal wenstrud
		1	
Service meets criteria for "approval via protocol"		Mooden	g Since 4/05.
		1	
Place a check mark (✓) in the Service Type re complete additional applicabl	equested (one only) and	Wast no	en 1
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Estimated Date of Service (mm/dd/yy)	1 1	a feras NI.	1000 110 C
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	diation therapy	/Vach	als 10 depend
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Specialist referred to: UNS	1 1	Previous treatment and	response (including medications):
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Type of Consultation, Treatment, Procedure of	or Surgery:	5 000 /000	and some it.
VelV!	5	proved	~ not responding
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Diagnosis: abnormal you, ble	eeding-Tup		
ICD-9 code:	1. Car		
You must include copies of pertinent reports ray interpretations and specialty consult repo	such as lab results, x		
Pertinent Documents have been attached		""For security and	safety, please do not inform patient of
LIER DETERMINATION		<u> L</u>	e follow-up appointments***
UM DETERMINATION:	Offsite Service Recommended a	nd Authorized	
Alternative Treatment Plan (explain here):		CIND	AL DIAGNOSTIS
More Information Requested: (See Attached)		ULUD/	AL DIAGNOSTIC SERVICES
D	ate resubmitted:	US	Pelace ECHO
Resubmitted with requested information.		חאת	IS!
Regional Medical Director Signature,		UAIL	12/0/05 INITIALS 4. Por
printed name and date required:			31: 05-700
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Please send this form v	ith the Authorization Letter to the DEMOGRAP		time of the appointment	
Size Namo & Number:	Patient Namo: (Lagr. Firet.)	TROO	Dato: (mituad/yy)	
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844 - TUTWILER		(b/a	7	
Site Phone #	Alias: (Last First)		Date of Birth: (mmldd/y)	
334-514-6269	Manulor	elora	11261	143
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Responsible party: New Inc.	Other, be specific (Excludes Med			
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Samuel Engelhardt, M.D.	9/1/	History of History Industry	sypintoms with Date of O	7.1
Facility Medical Director Signature and	Date	MININ	near meni	, men
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Place a check mark (/) in the Service T	ype requested (one unity) and alcable fields.	not re	8 porling 7	r
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ray interpretations and specialty con		For security	and safety, please do ne Sible follow-up appoints	renta***
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89 3943 VV	ABLIMILER			J1/11/2005 16:25

Case 2:06-cvbbhhZATHONDSANAGEMENT	agible You must Time or D.				
Flease send this form with the Authorization Letter i	to the service provider at thee of the Appointment				
Site Name & Number: Patient Name: (Last, First,	RAPHICS				
844 - TUTWILER					
Macca,) ebra 4-16-5				
Site Phone # Alias: (Last, First,)	Date of Birth: (mm/dd/yy)				
334-514-6269 Site Fax # Inmate # Inmate #	Debra 11,26,54				
334-514-9559 Inmate #	PHS Custody Date: (mm/dd/yy)				
SS Number	Potential Release Date: (mm/dd/yy)				
Will there be a charge? Sex ☑ Yes ☐ No ☐ Male ☑ Female ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1985 05,23,20				
Responsible party:	are/Medicaid Managed Care alternative plans) Medicare, Medicaid and Veterans Administration Services):				
CLINIC	AL DATA				
Requesting Provider: Physician NP, PA Deptai					
Samuel Engelhardt, M.D.	History of illness/injury/sypmtoms with Date of Onset:				
Facility Medical Director Signature and Date	abnormal menstrud				
	10 0 4/15				
Service meets criteria for "approval via protocol"	Keeding since 1101;				
Place a check mark (/) in the Service Type requested (one only) and complete additional applicable fields.	not responding to				
☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)	Results of a complaint directed physical examination:				
Outpatient Surgery (OS) Dialysis (DA)	Morres -				
A Koutine Urgent	12 lerus N/ Pa/ous 5/20				
Estimated Date of Service (mm/dd/yy)	William NI. Porous				
(This starts the approval window for the "open authorization period")	Theel 415 to depet				
Multiple Visits/Treatments: Radiation therapy Chemotherapy Chemotherapy					
Specialist referred to: UTV Strend					
Type of Consultation, Treatment, Procedure or Surgery:	provere not responding				
/	A 51 105				
Diagnosis: abnormal vag, bleeding - DUB					
You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.	***Eor coouries and cofety places do not inform that				
Pertinent Documents have been attached and faxed.	***For security and safety, please do not inform patient of possible follow-up appointments***				
UM DETERMINATION: Offsite Service Recommended	and Authorized				
Alternative Treatment Plan (explain here):					
More Information Requested: (See Attached)					
Date resubmitted: Resubmitted with requested information.					
Regional Medical Director Signature, printed name and date required:					
Do not write below this No. 7	/ / (mm/sksh				
	Manager and Corporate Data Entry ONLY.				
Cert Type: Med Classs CPT code:	UR Auth#:				
05a - UM Referral review form: XIS- 1111 - C S C 10 of C					

Case 2:06-cv-00172-WHINDACSCAER DSURIGIDENT ASSOCIATES FILE d 06/05/2006 Page 11 of 33 .. 2055 EAST SOUTH BLVD., SUITE 603 MONTGOMERY, AL 36116 Insurance and billing inquiries only AMERICAN BOARD L. LOMATES Phone (334) 281-9730 OF SURGERY TAX I.D. 63-0634673 (334) 281-9000 GEVERAL AND PARIPHERAL LASCULAR SURGERY 1-800-886-1231 151631 **GUARANTOR NAME AND ADDRESS** PATIENT NO. PATIENT NAME DOCTOR NO. DATE DEBRA CLACKER .Ø6394 DEBRA CLACKER Ø7/13/05 8966 US HWY 231 DATE OF កិន្តប៉ូប៉ូក្ TELEPHONE INSURANCE WETUMPKA AL 36092 BIRTH NUMBER CODE DESCRIPTION CERTIFICATE NO. 50 FEMALE 2161ARISON HEALT4|7809985 1726754 **0**000-000 FICE VISU BIOPSIES NEW **ESTABLISHED** INJECTIONS SKIN/SUBCUTANEOUS 11100 BIEF 99211 TETANUS TOXOID 90703 SKIN/SUBCUT - EACH ADDI 11101 BRIEF 99201 LIMITED 39212 NERVE INJECTION 64425 *BREAST - NEEDLE 19100 ___ LIMITED 99202 ___ INTERMED 99213 JOINT INJECTION/ASPIRATION 20605 MUSCLE SUPERFICIAL 20200 INTERMED 99203 EXTENDED 99214 . TRIGGER/FINGER 20550 *MUSCLE-NEEDLE 20206 _ EXTENDED 99204 ... COMPREH 99215 'THYROID NEEDLE 60100 _ COMPREH 99205 OTHER SURG PRO 99025 NO CHARGE PROCTOSCOPY & ANOSCOPY ... I & D PERINEAL ABCESS 99024 56405 L 1 & D PERIANAL ABCESS PROCTOSCOPY 46050 45300 CONSULTATIONS SECOND OPINIONS PROCTOSCOPY W/BIOPSY CATH/PORT REMOVAL 45305 36535 **NEW & ESTAB** NEW & ESTAB. PROCTOSCOPY W/DILATION 45303 LIMITED 99241 -LIMITED 99271 OTHER ANOSCOPY 46600 ... INTERMED 99242 _____ INTERMED 99272 ANOSCOPY W/DILATION 46604 _ EXTENDED 99243 __ EXTENDED 99273 ANOSCOPY W/Biopsy 46606 _ COMPREH 99244 ____ COMPREH 99274 **NAIL PROCEDURES** ... COMPLEX 99245 ____ COMPLEX 99275 *DEBRIDEMENT 1-5 11700 **DEBRIDEMENT - SKIN** DEBRIDEMENT ea addi 5 11701 PARTIAL THICKNESS *NAIL REMOVAL (1st) 11040 11730 FULL THICKNESS NAIL REMOVAL (2nd) RETURN TO DOCTOR 11041 11731 ... NAIL REMOVAL (ea over 2) FOREIGN BODY REMOVAL 11732 SUBUNGAL, HEMATOMA EVAC WEEKS MONTH(S) 11740 FAR(S) SKIN, SIMPLE 10120 *PARONYCHIA PRN 10060 SKIN, COMPLICATED 10121 *MUSCLE, SUPERFICIAL SIMPLE SKIN REPAIR 20520 QIAGNOSIS 1CD 9 ANAL W/ANOSCOPY TRUNK, SCALP, EXTREMITIES 46608 *0.1cm-2.5cm 12001 HEMORRHOIDS 12.6cm-7.5cm 12002 INCISION-THROMBOSED 46083 *7.6cm-12.5cm 12004 _ BANDING-SIMPLE 46221 over 12.5cm **EXCISION-EXTERNAL TAG** 46230 FACE, HANDS, FEET *0.1cm-2.5cm **EXCISION-THROMBOSED** HOSP PROC/DX IN/OUT B BSC JXN MSC EM 46083 12011 _ 12.6cm-7.5cm 12013 **INCISION & DRAINAGE** ADM DT. *7.6cm-12.5cm 12014 *CYST/ABSCESS - SIMPLE 10060 SURG DT __ over 12.5cm _ CYST/ABSCESS - COMPLEX 10061 *PILONIDAL - CYST - SIMPLE MISCELLANEOUS PROCEDURES 10080 PILONIDAL - COMPLICATED 10081 UNNA BOOT 29580 *HEMATOMA - SIMPLE 10140 CHG GAST/TUBE 43760 *POSTOPERATIVE WOUND 10160 MED REC/RPT DATE OF LAST PAYMENT 99080 *PERINEAL ABSCESS 56405 MED TESTIMONY 99075 *PERIANAL ABSCESS 46050 INSURANCE PATIENT **BREAST PROCEDURES** *CYST ASPIRATION (1) 705,00 PREVIOUS BALANCE . VõV 19000 REFERRING PHYSICIAN __ EACH ADDL CYST 19001 ... *NEEDLE BIOPSY 19100 TODAY'S CHARGES MASS EXCISION 19120 SAMUEL ENGLEHARDT MD PAID ON ACCOUNT **EXCISIONS-BENIGN SKIN LESIONS** CHECK CASH TRUNK & EXTREMITIES SCALP, NECK, HANDS, FEET ADJ. FACE & EARS Size __1140____ __ Size_____1142__ ___ Size_ 1144 TOTAL DUE SHAVING-LESIONS TRUNK & EXTREMITIES SCALP, NECK, HANDS, FEET **FACE & EARS** RELEASE, ASSIGNMENT AND RESPONSIBILITY (____ 1130____ Size_____ 1130__ ____ Size___ _ 1131 _ hereby authorize the undersigned Physician to release ar information acquired in the course of my child's examinatic ULTRASOUND GUIDED PROCEDURES or treatment. I also authorize payment directly to the undersigned physician of the surgical and/or medic _ DIAGNOSTIC ULTRASOUND, BREAST 76645 ... TEMPORAL ARTERY BIOPSY 37609 ULTRASOUND GUIDED NEEDLE BREAST BIOPSY benefits. It is understood that any monies received from the ULTRASOUND GUIDED BREAST CYST ASPIRATION insurance company over and above my indebtedness will t U/S GUIDANCE, NEEDLE CORE 76942 U/S GUIDANCE, CYST ASPIRATION 76938 refunded to me when bill is paid to full. I understand that I a __ NEEDLE CORE BIOPSY 19100 _ CYST ASPIRATION financially responsible for any collection fees, afforney fee 19000 ADDITIONAL NEEDLE CORE BIOPSY 19100 ADDITIONAL CYST ASPIRATIONS or count costs should my account become delinquent. 19001

ULTRASOUND GUIDED THYROID CYST ASPIRATION

U/S GUIDANCE, CYST ASPIRATION 75938

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Signed

- DIAGNOSTIĆ ULTRASOUND, THYROID

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UTILIZATION " ANAGEMENT REFERRAL RE" "EW FORM Case 2:06-cv-00172-WHA-OS Crust Document 26th 3you must be 605/2006 Page 12 of Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS Site Name & Number: Patient Name: (Last, First.) Date: (mm/dd/yy) 844 - TUTWILER Site Phone # Date of Birth: (mm/dd/yy) 334-514-6269 Site Fax # Inmate # 159576 334-514-9559 SS Number Potential Release Date: (mm/dd/yy) Will there be a charge? ✓ Yes
☐ No ☐ Male ☑ Female ✓ PHS Health Ins.(Excludes Medicare/Medicald Managed Care alternative plans) Responsible party: Auto Ins. Other, be specific (Excludes Medicare, Medicald and Veterans Administration Services): **CLINICAL DATA** Requesting Provider: Physician NP, PA Dental Dental History of illness/injury/sypmtoms with Date of Onset: Winfred Williams, M.D. Lyona Resection 6/28/05 Facility Medical Director Signature and Date: Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields. Office Visit (OV) Results of a complaint directed physical examination: X-ray (XR) Scheduled Admission (SA) Outpatient Surgery (OS) Dialysis (DA) Post of day will Needs F/u Appt. Z Routine ☐ Urgent Estimated Date of Service (mm/dd/yy) (This starts the approval window for the "open authorization period") Radiation therapy Multiple Visits/Treatments: Chemotherapy Number of Visits/Treatments: Other: Specialist referred to: Daly Previous treatment and response (including medications): Lipono Resocki Type of Consultation, Treatment, Procedure or Surgery: Flu upoma Rosecter Diagnosis: Tipoma ICD-9 code: You must include copies of pertinent reports such as lab results, ray interpretations and specialty consult reports with this form. ***For security and safety, please do not inform patient of possible follow-up appointments*** Pertinent Documents have been attached and faxed. UM DETERMINATION: Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here): More Information Requested: (See Attached) Date resubmitted: Resubmitted with requested information. Regional Medical Director Signature, printed name and date required: (mm/dd/yy Do not write below this line. For Case Manager and Corporate Data Entry ONLY. Cert Type: Med Class: CPT code:

05a-UM Referral review form Dr. Dan Daly with Montgonery Surgical Associates

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PAGE 02

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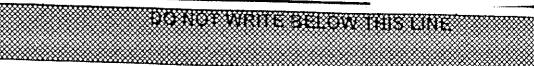


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NOTICE OF PRIVACY PRACTICES OF BAPTIST HEALTH AND ITS' AFFILIATED CORPORATIONS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

BAPTIST. This Notice describes the privacy practices of Baptist Health and all of its programs and departments, including Baptist Medical Center South, Baptist Medical Center East, Prattville Baptist Hospital; and its' affiliated corporations Montgomery Baptist Outreach Services, d/b/a Montgomery Family Medicine Residency Program; Baptist Ventures Inc., d/b/a Montgomery Surgery Center, Baptist Tower Pharmacy, and the five Primed locations; and Health Insurance Corporation of Alabama, all collectively referred to as "Baptist".

MEDICAL STAFF. This Notice also describes the privacy practices of an "organized health care arrangement" or "OHCA" between Baptist and eligible providers on its' Medical Staffs. Because Baptist is a clinically-integrated care setting, our patients receive care from Baptist staff and from indepedent practioners on the Medical Staffs. Baptist and its' Medical Staffs must be able to share your medical information freely for treatment, payment and health care operations as described in this Notice. Because of this, Baptist and all eligible providers on the Hospital' and other entities' Medical Staffs have entered into the OHCA under which Baptist and the eligible providers will:

- Use this Notice as a joint notice of privacy practices for all inpatient and outpatient provision of medical care and follow all information practices described in this notice;
- Obtain a single signed acknowledgement of receipt; and
- Share medical information from inpatient and outpatient provision of medical care with eligible providers so that they can help Baptist with its' health care operations.

The OHCA does not cover the information of practices of practioners in their private offices or at other practive locations.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The following are the types of uses and disclosures we may make of your medical information without your permission. Medical information includes items such as your diagnosis, medications, medical history, and insurance payment information, which identifies you. Where State or federal law restricts one of the described uses or disclosures, we follow the requirements of such State or federal law. These are general descriptions only. They do not cover every example of disclosure within a category.

Treatment. We will use and disclose your medical information for treatment. For example, we will share medical information about you with our nurses, your physician and others who are involved in your care at Baptist. We will also disclose your medical information to your physician and other practioners, providers and health care facilities for their use in treating you in the future. For example, if you are transferred to a nursing facility, we will send medical information about you to the nursing facility.

PHS0282

Payment. We will use and disclose your medical information for payment purposes. For example, we will use your medical to prepare your bill and we will send medical information to your insurance company with your bill. We may also disclose medical information about you to other medical care providers, medical plans and health care clearinghouses for their payment purposes. For example, if you are brough in by ambulance, the information collected will be given to the ambulance provider for it billing purposes. If State law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for payment purposes.

Health Care Operations. We may use or disclose your medical information for our health care operations. For example, medical staff members may review your medical information to evaluate the treatment and services provided, and the performance of our staff in caring for you. In some case, we will furnish other qualified parties with you medical information for their health care operations. The ambulance company, for example, may also want information on your condition to help them know whether they have done an effective job of providing care. If State law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for their operations.

Business Associates. We will disclose your medical information to our business associates and allow them to create, use and disclose your medical information to perform their job. For example, we may disclose your medical information to an outside billing company who assists us in billing insurance companies.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical services.

Treatment Alternatives. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising. We may contact you as part of a fundraising effort. We also disclose certain elements of your medical information, such as your name, address, phone number and dates you received treatment or services, to a business associate or a foundation related to Baptist so that they may contact you to raise money for Baptist. If you do not wish to be contacted regarding fundraising, please contact the Baptist Health Care Foundation at 334-273-4567, or mail your request to Baptist Health Care Foundation, P.O. Box 241647, Montgomery, Alabama 36124-1647.

Facility Directory. We may include your name, location in the facility, general condition and religious affiliation in a facility directory. This information may be provided to members of the clergy and, except for religious affiliation, to other prohibited by State or federal law.

Family and Friends. We may disclose your location or general condition to a family member or your personal representative. If any of these individuals or others you identify are involved in your care, we may also disclose such information as is directly relevant to their involvement. We will only release this information if you agree, are given the opportunity to object and do not, or if in our proffesional judgement, it would be in your best interest to allow the person to receive the information or act on your behalf. For example, we may allow a family member to pick up your prescriptions, medical supplies or X-rays. We also may disclose your information to an entity assisting in disaster relief efforts so that your family or individual responsible for your care may be notified of your location and condition.

Required by Law. We will use and disclose your information as required by federal, State or local law.

Public Health Activities. We may disclose medical information about you for public health activities. These activities

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability;
- To appropriate authorities authorized to receive reports of child abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

PHS0283

Abuse, Neglect or Domestic Violence. We may notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law, we will only make this disclosure if you agree.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliances with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpeona, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

Law Enforcement. We may release certain medical information if asked to do so by law enforcement official:

- As required by law, including reporting wounds and physical injuries;
- In response to a court order, subpeona, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if we obtain the individual's agreement or, under certain limited circumstances if we are able to obtain the individual's agreement:
- To alert authorities of a death we believe may be the result of criminal conduct;
- Information we believe is evidence of criminal conduct occurring on our premises; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Deceased Individuals. We may release medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.

Organ, Eye or Tissue Donation. We may release medical information to organ, eye or tissue procurement, transplantation or banking organizations or entities as necessary to facilitate organ, eye or tissue donation and transplantation.

Research. Under certain circumstances we may use or disclose your medical information for research, subject to certain safeguards. For example, we may disclose information to researchers when their research has been approved by a special committee that has reviewed the research proposal and established protocols to ensure the privacy of your medical information. We may disclose medical information about you to people preparing to conduct a research project, but the information will stay on-site.

Threats to Health or Safety. Under certain circumstances, we may use or disclose your medical information to avert a serious threat to health and safety if we, in good faith, believe the use or disclosure is necessary to prevent or lessen the threat and is to a person reasonably able to prevent or lessen the threat (including the target) or is necessary for law enforcement to identify or apprehend an individual involved in a crime.

Specialized Government Functions. We may use and disclose your medical information for national security and intelligence activities authorized by law or for protective services of the President. If you are a military member, we may disclose to military authorities under certain circumstances. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may dosclose to the institution, its agents or the law enforcement official your medical information necessary for your health and the health and safety of other individuals.

Workers' Compensation. We may release medical information about you as authorized by law for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conduction out business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Other Uses and Disclosures. Other uses and disclosure of your medical information not covered above will be made only with your written permission. If you authorize us to use and disclose your information, you may revoke that authorization at any time. Such revocation will not affect any action we have taken in reliance on your authorization.

INDIVIDUAL RIGHTS

Request for Voluntary Restrictions. You have the right to request a restriction on how we use and disclose your medical information for treatment, payment and health care operations, or to certain family members or friends identified by you who are involved in your care or the payment for your care. We are not required to agree to your request, and will notify you if

Access to Medical Information. You may request to inspect and copy much of the medical information we maintain about you, with some exceptions. If you request copies, we will charge you a copying fee plus postage.

Amendment. You may request that we amend certain medical information that we keep in your records. We are not required to make all requested amendments but will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

Accounting. You have the right to receive an accounting of certain disclosures of your medical information made by us or our business associates. The first accounting in any 12-month period is free; you may be charged a fee for each subsequent accounting you request within the same 12-month period.

Confidential Communications. You may request that we communicate with you about your medical information in a certain way or at a certain location. We must agree to your request if it is reasonable and specifies the alternate means or locations.

How to Exercise These Rights. All requests to exercise these rights must be in writing. We will follow written policies to handle requests and notify you of our decision or actions and your rights. For more information or to obtain request forms, please contact the Privacy Office as indicated below.

ABOUT THIS NOTICE

We are required to follow the terms of the Notice currently in effect. We reserve the right to change our practices and the terms of this Notice and to make new practices and notice provisions effective for all medical information that we maintain. Before we make such changes effective, we will make available. The revised Notice will also be posted on our website at **www.baptistfirst.org.** You are entitled to receive thie Notice in written form. Please contact the Privacy Officer at the address listed below to obtain a written copy.

PHS0285

COMPLAINTS

If you have concerns about any of our privacy practices or believe that your privacy rights have been violated, you may file a complaint with Baptist using the contact information at the end of this Notice. You may also submit a written complaint to Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta GA 30303-8909. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

Privacy Officer Baptist Health 301 Brown Springs Road Montgomery, Alabama 36117

tel 334-273-4417 fax 334-273-4415

Mailing Address; PO Box 244001 Montgomery, Alabama 36124-4001

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EFFECTIVE DATE: April 14, 2003

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Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Med Class:

Regional Medical Director Signature, printed name and date required:

· 05a - UM Referral review form

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Case 2:06-cv-00172-WHA-CSC Document 21-13 Filed 06/05/2006 Page 23 of 33

TRANSMISSION VERIFICATION REPORT

TIME : 05/23/2005 13:42 NAME : TUTWILER FAX : 3345149559 TEL : 3345146269

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ENT-REFERIEA befos/125 M FOR Me 25 of Please send this form with the Authorization Letter to the service provider at the time of the Appointment **DEMOGRAPHICS** Site Name & Number: Patient Name: (Last, First,) Date: (mm/dd/yy) 844 - TUTWILER Site Phone # 334-514-6269 Site Fax # 334-514-9559 SS Number Will there be a charge? Sex Potential Release Date: (mm/dd/yy) ☐ Male ☑ Female ✓ Yes
☐ No ✓ PHS Health Ins. (Excludes Medicare/Medicald Managed Care alternative plans) Responsible party: Auto Ins. Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services): CLINICAL DATA Requesting Provider: Physician NP, PA ☐ Dental Samuel Engelhardt, M.D. History of Illness/injury/sypmtoms with Date of Onset: Facility Medical Director Signature and Date: Service meets criteria for *approval via protocol* Place a check mark (') in the Service Type requested (one only) and complete additional applicable fields. Office Visit (OV) X-ray (XR) Scheduled Admission (SA) Results of a complaint directed physical examination: Outpatient Surgery (OS) Dialysis (DA) Routine-Urgent | Estimated Date of Service (mm/dd/yy) (This starts the approval window for the "open authorization period") Multiple Visits/Treatments: Radiation therapy ☐ Chemotherapy Number of Visits/Treatments: Other: Specialist referred to: Previous treatment and response (including medications): Type of Consultation, Treatment, Procedure or Surgery: Diagnosis: Ly ICD-9 code: You must include copies of pertinent reports such as lab results, ray Interpretations and specialty consult reports with this form. ***For security and safety, please do not inform patient of Pertinent Documents have been attached and faxed, possible follow-up appointments*** UM DETERMINATION: Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here): More Information Requested: (See Attached) Date resubmitted: Resubmitted with requested information, Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY. Cert Type:

105a - UM Referral review form Dr. Dan Daly with Montgomery Surgical

CPT code:

Med Class:

UR Auth #:

Case 2:06-cv-00172-WHMOCSCMERDOUBCREAT RS-08/ATE-F, Head 06/05/2006 Page 26 of 33 Insurance and billing inquiries only __...55 EAST SOUTH BLVD., SUITE 603 Phone (334) 281-9730 MONTGOMERY, AL 36116 TAX I.D. 63-0634673 (334) 281-9000 1-800-886-1231 ND PERIPHERAL ULAR SURGERY 150165 **GUARANTOR NAME AND ADDRESS** PATIENT NO. PATIENT NAME DOCTOR NO. DATE DEBRA CLACKER 06394 DEBRA CLACKER **13**15/ 16705 8966 US HWY 231 METUMPKA AL 36092 DATE OF **TELEPHONE** INSURANCE BIRTH NUMBER DESCRIPTION CODE CERTIFICATE NO. 0 FEMALE 8161PRISON HEALT417809985 1726754 *ቑ*፞፞፞ፙፙኯፙፙፙቑ OFFICE VISITS BIOPSIES NEW **ESTABLISHED** INJECTIONS SKIN/SUBCUTANEOUS 11100 BRIEF TETANUS TOXOID 90703 _ SKIN/SUBCUT - EACH ADDL 11101 ___ BRIEF 99201 _ LIMITED 99212 NERVE INJECTION 'BREAST - NEEDLE 64425 19100 ___ LIMITED 99202 ... — INTERMED 99213 JOINT INJECTION/ASPIRATION ... MUSCLÉ SUPERFICIAL 20605 20200 INTERMED 99203 - EXTENDED 99214 TRIGGER/FINGER 20550 *MUSCLE-NEEDLE 20206 EXTENDED 99204 COMPREH 99215 'THYROID NEEDLE 60100 COMPREH 99205 OTHER SURG PRO 99025 NO CHARGE PROCTOSCOPY & ANOSCOPY ... L& D PERINEAL ABCESS 99024 56405 PROCTOSCOPY . I & D PERIANAL ABCESS 45300 CONSULTATIONS 46050 SECOND OPINIONS PROCTOSCOPY W/BIOPSY __ CATH/PORT REMOVAL 45305 36535 NEW & ESTAB. NEW & ESTAB. PROCTOSCOPY W/DILATION 45303 CIMITED 99241 LIMITED 99271 ANOSCOPY OTHER 46600 .. INTERMED 99242 INTERMED 99272 _ ANOSCOPY W/DILATION 46604 ___ EXTENDED 99243 ... _ EXTENDED 99273 ANOSCOPY W/BIOPSY 46606 COMPREH 99244 COMPREH 99274 COMPLEX NAIL PROCEDURES 99245 ____ COMPLEX 99275 *DEBRIDEMENT 1-5 11700 DEBRIDEMENT - SKIN DEBRIDEMENT ea addi 5 11701 _ PARTIAL THICKNESS 11040 - "NAIL REMOVAL (1st) 11730 FULL THICKNESS ... NAIL REMOVAL (2nd) 11041 RETURN TO DOCTOR 11731 ... NAIL REMOVAL (ea over 2) FOREIGN BODY REMOVAL 11732 SUBUNGAL, HEMATOMA EVAC MONTH(S) _WEEKS 'SKIN, SIMPLE 11740 YEAR(S) 10120 *PARONYCHIA 10060 PRN SKIN, COMPLICATED 10121 'MUSCLE, SUPERFICIAL 20520 SIMPLE SKIN REPAIR DIAGNOSIS ANAL W/ANOSCOPY 46608 TRUNK, SCALP, EXTREMITIES *0.1cm-2.5cm **HEMORRHOIDS** 12001 *2.6cm-7.5cm 12002 _ INCISION-THROMBOSED 46083 *7.6cm-12.5cm 12004 _____ BANDING-SIMPLE 46221 ... over 12.5cm EXCISION-EXTERNAL TAG 46230 FACE, HANDS, FEET EXCISION-THROMBOSED 46083 *0.1cm-2.5cm HOSP PROC/DX IN/OUT B BSC JXN MSC EM 12011 - *2.6cm-7.5cm 12013 INCISION & DRAINAGE ADM DT ___/_ *7.6cm-12.5cm 12014 ... 'CYST/ABSCESS - SIMPLE 10060 SURG DT __/__/__ over 12.5cm . ___ CYST/ABSCESS - COMPLEX 10061 ... 'PILONIDAL - CYST - SIMPLE MISCELLANEOUS PROCEDURES 10080 ____ PILONIDAL - COMPLICATED 10081 - UNNA BOOT 29580 'HEMATOMA - SIMPLE 10140 - CHG GAST/TUBE *POSTOPERATIVE WOUND 43760 10160 - MED REC/RPT 99080 'PERINEAL ABSCESS 56405 MED TESTIMONY 99075 'PERIANAL ABSCESS 46050 INSURANCE PATIENT **BREAST PROCEDURES** *CYST ASPIRATION (1) 19000 PREVIOUS BALANCE REFERRING PHYSICIAN EACH ADDL CYST 19001 NEEDLE BIOPSY 19100 TODAY'S CHARGES 19120 SAMUEL ENGLEHARDT MD _ MASS EXCISION PAID ON ACCOUNT **EXCISIONS-BENIGN SKIN LESIONS** CHECK CASH TRUNK & EXTREMITIES SCALP, NECK, HANDS, FEET **FACE & EARS** AD.I _ 1140___ _ __ Size_ __ Size_ ____ 1144__ TOTAL DUE SHAVING-LESIONS TRUNK & EXTREMITIES SCALP, NECK, HANDS, FEET **FACE & EARS** RELEASE, ASSIGNMENT AND RESPONSIBILITY (___ 1130____ Size_____ 1130 _ Size____1131 __ hereby authorize the undersigned Physician to release a ULTRASOUND GUIDED PROCEDURES information acquired in the course of my child's examinat or treatment. I also authorize payment directly to _ DIAGNOSTIC ULTRASOUND, BREAST 76645 _ TEMPORAL ARTERY BIOPSY undersigned physician of the surgical and/or med 37609 ULTRASOUND GUIDED NEEDLE BREAST BIOPSY ULTRASOUND GUIDED BREAST CYST ASPIRATION benefits. It is understood that any monies received from insurance company over and above my indebtedness will _ U/S GUIDANCE, NEEDLE CORE 76942 U/S GUIDANCE, CYST ASPIRATION 76938 refunded to me when bill is paid in full. I understand that I _ NEEDLE CORE BIOPSY 19100 CYST ASPIRATION 19000 financially responsible for any collection fees, attorney fe _ ADDITIONAL NEEDLE CORE BIOPSY 19100 ADDITIONAL CYST ASPIRATIONS 19001 or court costs should my account become delinquent. - DIAGNOSTIC ULTRASOUND, THYROID ULTRASOUND GUIDED NEEDLE THYROID BIOPSY ULTRASOUND GUIDED THYROID CYST ASPIRATION

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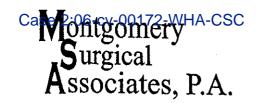
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Alex V. Kreher, Jr., MD, FACS Daniel M. Daly, MD, FACS Robert B. Harris, MD, FACS

www.montgomerysurgical.com

Jimmy Norman, CPA Administrator

May 16, 2005

Dr. Samuel Engelhardt Julia Tutwiler Prison Health Care Unit 8966 US Highway 231 Wetumpka, AL 36092

RE: Debra Clackler

Dear Dr. Engelhardt:

I saw Debra Clackler in the office today for evaluation of a couple of problems. I told her I would take care of the left flank lipoma with excision of this as an outpatient. Her right-sided abdominal pain seems to originate just above the umbilicus and radiate toward the right abdomen and right flank. She has an area that is tender just above the umbilicus. I suspect she may have a small incisional hernia at the bottom of her cholecystectomy scar. However, I was unable to definitely detect a hernia. I told her I would explore the area or proceed with a hernia repair only if she developed a clinically detectable hernia. I told her I would like to see her back again in a few months to reexamine the area.

Thank you for allowing me to be of assistance in the care of Ms. Clackler.

Sincerely,

Daniel M. Daly, M.D.

DMD/mpf

PHS0294

Baptist South Office 2055 E. South Bivd., Suite 603 Montgomery, AL 36116-2463 (334) 281-9000 Fax (334) 281-8262

Baptist East Office 440 Taylor Road, Suite 3380 Montgomery, AL 36117 (334) 409-9683 Fax (334) 409-9258 Prattvale Office

645 McQueen Smith Rd, Ste 102

Prattville, AL 36066

(334) 361-0711

Fax (334) 358-0370

Case 2:06-cPRISPINIFIAESCH SEBNIGES2 AUTHORUZOS/05)2006ETPERe 28 of 33

Patient Name:	Clackler, Debra	Inmate Number:	159516CL
Service Authorized:	Office Visits: General Surgery Consult	Effective Dates:	04/12/2005
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Tutwiler Prison For Women	Contact Name:	Michelle Pope
Authorization Number:	14906957	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

The consulting physician should complete this section.

The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

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*** For security and safety, please do not inform patient of possible follow-	-up appointments. ***
Signature of Consulting Physician:	-(6-) Time
Reviewed and Signed By	Time
Medical Director: Date	Time

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM Figure send this form with the Authorization Latter to the service provider at the time of the Appointment PIR DEMOGRAPHICS Name of Chinasia अवित्वसारामाम् (स्टब्स्स (स्टब्स् 844 - TUTWILER r Webro Sild Pilone # 334-514-6269 elora Site For # 334-514-6559 Will there be a obserge? SS Number ☑ YC# □ NO Make 🖸 Female Hookin Irm. (Broketer Modicard/Medicald Managed Care atternative plans) Z PHS Responsible party: AKRA INS Citives, be specific (Excludes Hyercare, Medicaid and Veterans Administration Services) CLINICAL DATA Requesting Provider Physician INP, MA Dontal John Peasant, M.D. History of Illiness/Injury/sypmtoms with Date of Onest: Pacility MicCopi Director Signature and Date: Servicestriasto catache for "approved via photocol" Place a check mark (*) in the Service Type requested (one only) and complete additional applicable fields. Office Vielt (OV) X-ay (XX) Scheduled Admission (5%) Results of a complaint directed physical examination: Outputions Surgery (DS) DIONAR (DA) - Accepting Constant Estimated Date of Service (mm/dd/yy) Lipis stars are subleaved muchon ten gib "ohes anquesimmen bested. Multiple Vielta/Trestments: Rediction therapy Chemodiampy Number of Visital Treatments: Cither: Specialist referred to: DA D Provious treatment and response (including medications): Diagnools: (1) Dide COLD CODE You mount include copies of portinont reports such as ist results. ray interpretations and specially consult reports with this form. ***For security and safety, please do not inform patient of Pertinent Decements have been attached and finial. possible follow-up appointments UM DETERMINATION: Office Foreign Recommended and Authorized Alternative Profesional Plan (audido here): Hore Information Requiremed: (See Attached) Resultatives with requested betweenton. Regional Medical Director Signature, Will Mosion Will its below this fire. For Case Manager and Carpotate Data Driesy Office.

0001- UTA Referral review form Or, Dan Daly with Montgomery Surgical

REGIONAL OFFICE

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Case 2:06-cv-00172-NTA-CS-CANAGEMENT REFERRAL 08/05/EW/FORMge 30 of 33

Site Name & Number:				
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SS Number Potential Release Date: (mm/dd/yy)				
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Responsible party: PHS				
Auto Ins. Other, be specific (Excludes Medicare, Medicald and Veterans Administration Services):				
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UM DETERMINATION: Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here):				
More Information Requested: (See Attached)				
Date resubmitted:				
Resubmitted with requested information. Regional Medical Director Signature,				
printed name and date required:				
Do not write below this line. For Case Manager and Corporate Data Entry ONLY.				
Cert Type: Med Class: CPT code: UR Auth #:				

105a-UM Referral review form Dr. Dan Daly with Montgomery Surgical Associates

H SERVICES: AUTHORIZAT ON LETTER

Patient Name:	Clackler, Debta	- 171.2	- WEITER		
Service Authorized:	Office Visits: General Surgery Consult	Inmate Number:	159516CL		
Effective:	Visits authorized for 60 days from effective date.	Effective Dates:	04/12/2005		
Responsible Facility:	Turwiler Prison For Women	Visits Authorized:	1		
Additional and the Land	14906957	Contact Name:	Michelle Pope		
inte to Provider of Servic Medicare/Medicaid do no		Telephone Number:	(334)395-5973 Ext 14		

Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances

Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number) Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the

HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not

Payment will not be processed until we receive a clinical summary.

ir Payment Please Submit Claims To:

son Health Services

1 Box 967

intwood, TN 37024-0967

The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional for

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NaphCare Hospital/Consultant Referral Form

Inmate Name: CINCher Debin		_AIS#:_\ S9 J	116	_Date:	23
DOB: 11/26/54 Race: W Sen					
History of working diagrams (1)					
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OFFSITE HEALTHCARE REPORT:			<u> </u>	(4/1/1)	*************************************
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Advanced Medical Directive: Yes (Attache	ed) No _		P	o aisona go	••
Report called to: (Name/Title): \(\sum \)			Date:		
Signature & Title: WA			Date:		

Bill to NaphCare 950 22nd St. N. Suite 825 Birmingham, AL. 35203 Beverly Douglas, R.N. Utilization Review Manager* 205-458-8370 or 1-800-771-0315

030310TXL03

NaphCare Hospital/Consultant Referral Form

Inmate Name: Ackler Debra AIS#: 1595/6 Date: 3-6-03
DOB: 11-2654 Race: W Sex: Allergies: colony
History of working diagnosis (when first recognized, progression of symptoms, physical findings, lab results, current symptoms, current treatments): Lescale, Deuse breests Vain Q breast SERVICES REQUESTED/PROVIDER:
SERVICES REQUESTED/PROVIDER:
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Signature (M.D.):
Pertinent Chronic Conditions/Diagnosis: _A) [/]
100 Facility: The True Len - Time Out.
Receiving Facility/Hospital: 4 N 1 Return Time:
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Date & Result/Last PPD: 1-1503 00 mm Date & Result/Last Chest X-Ray NA
OFFSITE HEALTHCARE REPORT:
Orders/Recommendations: Orders/Recommendations:
Physician: Date: Time:
Notify (Facility): Turniff at: #() 5111-0219 of patient's discharge. Advanced Medical Directive: Yes (Attached) No
Report called to: (Name/Title): Date:
Signature & Title: Date: